

True Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: JULY 16, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy two to three times a week for four weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Physical therapy notes 05/02/07, 05/23/07, 06/08/07

MRI lumbar spine 05/17/07

Office notes of Dr. 05/23/07, 06/13/07

Review of 06/05/07

Review form 06/06/07

Physical therapy referral 06/13/07

Request for reconsideration

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his back. A physical therapy note dated 05/02/07 noted the claimant's complaints of low back pain radiating to both lower extremities to the knees only, left greater than right and some paresthesias in the anterior bilateral thigh regions. Decreased lumbar lordosis was noted in standing. Range of motion was: 100 percent flexion, 25 percent extension, 50 percent bilateral lateral flexion. Achilles reflexes noted a 2 beat clonus. There was a positive Spurling's test at L3-5, spasms in the lumbar paraspinal musculature and tenderness of the L3-5 spinous processes, interspinous ligaments, and in the left popliteal fossa as well as tightness of the hamstring, piriformis, lumbar paravertebral muscles, and to external rotation of the hip bilaterally. Therapy to include aquatics was recommended. A lumbar MRI performed on 05/17/07 noted mild lower lumbar spondylosis, a small disk bulge at L4-5 and a small central protrusion at L5-S1. Dr. evaluated the claimant on 05/23/07 for continued low back pain and lower extremity weakness despite therapy. The examination was normal. Dr. indicated that EMG studies, date unknown were normal. Low back syndrome, lumbar radiculopathy and lumbar disc herniation were diagnosed and bilateral L5-S1 transforaminal epidural steroid injections, Lortab and continuation of therapy were prescribed.

The request for additional therapy was denied on 06/05/07. A therapy note of 06/08/07 noted increased active range of motion with extensions in lying into his locked elbows. On 06/13/07 Dr. examination noted a positive straight leg raise at L4-5 with diminished sensation and strength. Apparently the requests for injections and therapy were denied. Bilateral L4-5 transforaminal injections and therapy were again prescribed. The therapy was denied and is again being requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The request for physical therapy two to three times a week for four weeks is not medically necessary or reasonable in this male who initially was injured and treated in Mexico. An MRI was repeated, which demonstrates mild lower lumbar spondylolysis, a small disc bulge at L4-5 and a small central protrusion at L5-S1. On Dr. evaluation on 05/22/07 demonstrates upper and lower extremities at 5/5 strength. Deep tendon reflexes were symmetric. An EMG was performed without signs of radiculopathy, either acute or chronic. The claimant already had 12 physical therapy visits. Based on upon all of this information, the Reviewer's medical assessment is that further physical therapy is unnecessary and appropriate. At this time this claimant should be able to carryout a home exercise program and achieve a similar benefit.

Official Disability Guidelines, Treatment in Worker's Comp, 2007 Updates, (i.e. Low Back-Physical Therapy)

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.

Intervertebral disc disorders: Medical treatment: 10 visits over 8 weeks.



A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)